STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

In the Matter of:
E. L. COX, COMMISSIONER OF INSURANCE,
FOR THE STATE OF MICHIGAN,

Petitioner,

-v-

File No. 98-88265-CR

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC., a Michigan health maintenance organization doing business as OmniCare Health Plan,

Hon. James R. Giddings

A.G. No. 1998053333A

Respondent.
_____/

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BRIEF REGARDING PRIORITY OF PROVIDER CLAIMS FOR PURPOSES OF THE LIQUIDATION OF MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC.

The hospitals and health systems identified below (hereinafter, the "Hospital Providers," by and through their attorneys, Nuyen, Tomtishen and Aoun, P.C., and pursuant to this Court's May 12, 2005 Corrected and Amended Order Setting Briefing Schedule and Establishing Notice Procedure With Respect to the Issue of The Priority of Provider Claims, hereby submit their Brief Regarding Priority of Provider Claims for

purposes of the liquidation of Michigan Health Maintenance Organization Plans, Inc. (f/k/a OmniCare) ("MHOP").

I. Identification of Hospital Providers

This Brief Regarding Priority of Provider Claims for Purposes of the Liquidation of Michigan Health Maintenance Organization Plans is submitted on behalf of the following hospitals and health systems, their employed physicians and their affiliated entities, as creditors of MHOP:

- Henry Ford Health System
- Henry Ford Health System, d/b/a Henry Ford Hospital (Detroit)
- Henry Ford Bi-County Hospital (Warren)
- Henry Ford Wyandotte Hospital (Wyandotte)
- Detroit Osteopathic Hospital Corp., d/b/a Riverside Osteopathic Hospital
- Oakwood Healthcare System
- Oakwood Hospital & Medical Center (Dearborn)
- Oakwood Annapolis Hospital (Wayne)
- Oakwood Heritage Hospital (Taylor)
- Oakwood Southshore Medical Center (Trenton)
- POH Medical Center (Pontiac)
- St. John Health
- St. John Hospital and Medical Center (Detroit)
- St. John Northshore Hospital (Harrison Township)
- St. John River District Hospital (East China Township)
- St. John Oakland Hospital (Madison Heights)
- St. John Northeast Community Hospital (Detroit)
- St. John Macomb Hospital (Warren)
- St. John Riverview Hospital (Detroit)
- Brighton Hospital (Brighton)
- Providence Hospital and Medical Center (Southfield)
- William Beaumont Hospital (Royal Oak)
- William Beaumont Hospital (Troy)

Each of the foregoing hospitals and health systems is a nonprofit corporation, tax-exempt under Internal Revenue Code Section 501(c)(3). Collectively, the foregoing hospitals and health systems have rendered tens of millions of dollars of covered health

care services to individuals enrolled in MHOP's health care programs, for which they have filed claims and not received payment.

II. Background

MHOP was a health maintenance organization ("HMO"). The vast majority of MHOP's HMO membership consisted of Medicaid beneficiaries enrolled with MHOP pursuant to a qualified health plan contract between it and the State of Michigan.

In 1998, MHOP was placed under seizure pursuant to Chapter 81 of the Michigan Insurance Code due to financial difficulties. Because MHOP's financial position further deteriorated, and in fact MHOP became massively insolvent, in July, 2001, this Court appointed the Commissioner of the Office of Financial and Insurance Services ("OFIS") as Rehabilitator of MHOP.

Following appointment, the Rehabilitator developed a plan of rehabilitation and an amended plan of rehabilitation ("Rehabilitation Plan") intended to allow MHOP to continue in existence in a stronger financial position. Health care provider creditors of MHOP, including the Hospital Providers, objected to the Rehabilitation Plan because it authorized MHOP to discharge tens of millions of dollars in health care provider creditor claims for pennies on the dollar and, at the same time, allowed MHOP to continue to operate despite the fact that, even after the write-offs, MHOP remained insolvent and still did not meet basic financial solvency criteria required of HMOs by law.[1] In fact, as a result of the Rehabilitation Plan, MHOP was allowed to discharge $67.7 million in claims liabilities to providers by issuing $14 million in surplus notes and paying $19.5 million in cash. This means that providers actually received $.29 in cash for each pre-rehabilitation

[1] See, e.g., Joint Supplemental Brief With Respect to Certain Legal Issues Arising Under the OmniCare First Amended Rehabilitation Plan, dated July 22, 2002.

dollar owed by MHOP. As we now know, the surplus notes will never be paid. Accordingly, through the previous rehabilitation proceedings, health care provider creditors already have been forced to write off more than $48 million in claims for health care services rendered to members of MHOP. No other category of creditor was forced to incur a write-off anywhere near the amount incurred by health care providers.

Health care provider creditors also objected to the Rehabilitation Plan because it required them to continue to do business with MHOP indefinitely, enjoining them from terminating their arrangements with MHOP, and mandating the continuation of those arrangements that otherwise would have expired by their terms.[2] Health care provider creditors objected to the injunction because, among other reasons, they did not want to be required to do business with an insolvent MHOP and feared a second write-off. In fact, health care providers feared, and predicted, the very circumstances which exist today – namely, that the State of Michigan would refuse to continue MHOP's qualified health plan due to its financial condition, MHOP would not be viable as a result, and would need to be liquidated without sufficient resources to pay creditor claims.[3] No other creditors with unpaid claims against MHOP were similarly required to continue to do business with an insolvent MHOP.

The Court approved the Rehabilitation Plan on July 29, 2002 and dismissed the health care provider creditors' objections. One of the reasons the Court was willing to approve the Rehabilitation Plan, including the features resulting in providers incurring a massive write-off and being locked-in to their contracts, was that MHOP had been paying, and

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[2] Id.

[3] See, e.g., Objections of William Beaumont Hospital to the Proposed OmniCare Rehabilitation Plan.

would continue to pay, post-rehabilitation claims in full. In fact, this Court ordered the Rehabilitator to ensure that all post-rehabilitation claims be paid in full.[4]

In the course of the rehabilitation, health care providers were repeatedly assured that they would be paid for services rendered on and after the institution of rehabilitation proceedings. *See* OmniCare Letter and Fact Sheet (the form and content of which were approved by the Attorney General's office) which states "If you submit a claim for the date of service of July 31, 2001 and thereafter, you will be paid." *See also* Office of Insurance and Financial Services Press Releases dated July 31, 2001 and March 14, 2002 (assuring payment will be made on a going forward basis). The foregoing documents are attached as Exhibit A.

Unfortunately, as we now know, MHOP is no longer in business, its most significant assets having been sold to Coventry Health of Michigan, Inc. in anticipation of the discontinuance of MHOP's Michigan qualified health plan contract last fall. As a result, the Rehabilitator petitioned this Court for, and was granted, an order permitting the liquidation of MHOP. What remains, amounts to approximately $17 million in assets to pay approximately $41 million in creditor claims.[5] Of the $41 million in creditor claims, the vast majority (83%) represents claims of health care providers (including approximately $14 million in surplus notes issued pursuant to the Rehabilitation Plan). Obviously, the available assets are insufficient to pay all creditor claims. Since they are entitled to the lowest priority, surplus notes issued to health care providers pursuant to the Rehabilitation Plan will not be paid at all. The remaining $19.9 million in health care

[4] Order Approving The Rehabilitation Plan and Discharging The Pre-Rehabilitation Debts of OmniCare In Accordance With The First Amended Rehabilitation Plan, pp. 9-10, ¶ 19; Order of Rehabilitation and Injunctive Relief, p. 3.

[5] See February 9, 2005 List of Assets of Michigan Health Maintenance Organization Plans, Inc. Filed Pursuant to MCL 500.8125.

provider creditor claims, which exceeds MHOP's $17 million in total assets, obviously will need to be compromised.

The Court has ordered that a hearing take place on July 20, 2005 to permit arguments by interested parties as to the respective priority that should be given to MHOP creditor claims for liquidation purposes. The Court's Order permitted interested persons, including health care provider creditors, to file briefs addressing the claim priority issue. As creditors of MHOP, the Hospital Providers are interested persons and hereby submit their brief.

III. Priority of Provider Claims

As an initial matter, it is noteworthy that the issue before the Court was recently addressed in Linda A. Watters, Commissioner, Office of Financial Services for the State of Michigan v. The Wellness Plan, File No. 03 1127 CR (Hon. William E. Collette presiding). In that matter, on June 8, 2005, the Court ruled from the bench that health care provider creditor claims are Class 2 claims under Section 8142 of the Michigan Insurance Code for purposes of determining the priority of distribution of assets to creditors of The Wellness Plan. Section 8142 is similarly at issue in this matter. As of the filing of this brief, the court's written order in The Wellness Plan matter had not yet been filed, executed and made publicly available. The Hospital Providers will supplement this filing and provide a copy of Judge Collette's order to this Court when it becomes available in the event it is not otherwise filed with the Court.

In The Wellness Plan matter, the Liquidator took the position that health care provider creditor claims deserve Class 2 treatment, and the Hospital Providers understand she will take a consistent position with regard to this matter. This Court should afford

deference and great weight to the interpretation given Section 8142 by the Liquidator, the Commissioner of OFIS and the person in charge of the state agency responsible for administering the Michigan Insurance Code. Davis v River Rouge Bd of Educ, 406 Mich 486, 490 (1979) ("[T]he construction placed upon a statute by the agency legislatively chosen to administer it is entitled to great weight."); See also Bruhan v Plymouth-Canton Community Schools, 425 Mich 278, 282-283 (1986); DAIIE v Comm'r of Ins, 119 Mich App 113, 119 (1982). As explained more fully below, the Liquidator's and Judge Collette's conclusion that health care provider claims deserve Class 2 treatment for purposes of Section 8142 is correct.

A. Application of Section 8142 to Provider Claims

MHOP providers are seeking payment for health care services which are explicitly covered under the health maintenance contracts issued by MHOP to its enrollees. Section 8142 of the Insurance Code, MCL § 500.8142, sets forth the priority of distribution of claims from an HMO's estate. The claims of health care providers, including MHOP Providers, are Class 2 claims for purposes of Section 500.8142. Section 500.8142(1)(b) defines Class 2 claims as "[A]ll claims under policies for losses incurred, including third party claims . . . ."

MCL § 500.3503 makes the provisions of Chapter 81, including Section 8142, applicable to HMOs. Reading Section 8142, Section 3503 and the remainder of Chapter 35 (Michigan's HMO Act) in pari materia, an HMO is an "insurer," health maintenance contracts are "policies," and an HMO's members/enrollees are "insureds" for purposes of applying Chapter 81, including Section 8142. See also MCL § 500.3501(d) and (e). It seems too obvious for words, therefore, that the medical expense payments made by

MHOP to a provider for health care services explicitly covered under MHOP's health maintenance contracts constitute "losses incurred" for purposes of Section 8142.

1. The Hospital Providers are Within The Class of Claimants Contemplated Under Class 2

There is nothing in the claims priority statute, Section 500.8142 (or elsewhere in Chapter 81 for that matter), prohibiting health care providers, such as the Hospital Providers, from being Class 2 claimants. As noted, Class 2 claims include "all claims under policies for losses incurred, including third party claims . . . ." MCL § 500.8142(1)(b). Accordingly, the scope of Class 2 claims is not limited to a specific category of claimant, such as insureds or, in the case of an HMO, its enrollees. Indeed, Class 2 claims specifically include "third party claims." This is not surprising since, as explained in detail below, in the context of HMOs, the regulatory scheme and operational practice of HMOs requires health care providers to submit claims directly to the HMO, and for the HMO to pay the health care provider directly. If this were not the case, and if providers billed HMO enrollees directly who then submitted the same claims for reimbursement to the HMO, there would be no question that the enrollees' claims would fall within Class 2.

This result should not change simply because the regulatory scheme and operational practice of HMOs requires providers to submit claims directly to the HMO, rather than requiring the HMO to bill the enrollee and the enrollee to submit the same claim to the HMO. As third party claimants seeking payment of benefits under health maintenance contracts issued by MHOP, MHOP Providers fall within the scope of claimants contemplated by Class 2.

2. HMO Provider Claims Should Be Afforded The Same Treatment As Claims of Insureds Under Traditional Indemnity Insurance

Chapter 81, including Section 8142, applies not only to HMOs, but to all insurers. MCL § 500.8102. It is important to understand, therefore, that there are significant differences between the manner in which HMOs and traditional indemnity insurers operate which must be considered to apply Section 8142 consistently.

In accordance with applicable law, MHOP must agree, pursuant to its health maintenance contracts, to deliver health care services to its enrollees through employees and contracted affiliated providers and to be financially responsible for the costs of those services. See MCL §§ 500.3501(f), 500.3529(2); 42 CFR § 438.206. One of the hallmarks of HMO coverage is the existence of a network of health care providers that are affiliated with the HMO, and the requirement that enrollees seek health care services only from providers affiliated with the HMO. In contrast, under traditional indemnity coverage the insurer does not have affiliated provider relationships and the insured is free to choose any health care provider when he or she requires health care services that are covered under the insurance policy.

Under the HMO Act, the health care services which MHOP must cover under its health maintenance contracts must include "basic health services." MCL § 500.3519(3). The term "basic health services" includes hospital services, such as those provided by MHOP Providers. MCL § 500.3501(b). Thus, the "losses" or "benefits" covered by MHOP, under its health maintenance contracts are the medical expense payments made in connection with delivering the covered health care services specified in its health maintenance contracts, including hospital services.

In this regard, HMOs and traditional indemnity health insurers are similar since both agree to be financially responsible for the cost of health care services covered under their policies/health maintenance contracts. Moreover, both receive and pay claims for covered health services rendered by health care providers although, as explained below, in the case of the traditional indemnity health insurer claims are received from the insured, while in the case of the HMO, claims are received directly from health care providers.

HMO providers, such as MHOP providers, that render health care services to an enrollee are prohibited from billing the enrollee for those services to the extent they are covered by the health maintenance contract. See MCL §§ 500.3529(3); 400.111b(14). In fact, this Court specifically acknowledged and reiterated the principle that health care providers cannot bill HMO enrollees in its various orders including, most recently, in its Order for Liquidating Receivership and Declaration of Insolvency dated October 28, 2004. On page 5 of that Order, this Court specifically enjoined all contracted and non-contracted health care service providers from billing MHOP members for health care services rendered to them.

Likewise, under Medicaid rules, providers such as MHOP providers are required to accept payment from Medicaid health plans, such as MHOP as payment in full (with the exception of copayments or services not covered under the health maintenance contract).[6] For example, the Medicaid Provider Manual states "Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in

[6] As a Medicaid HMO, MHOP was subject not only to the HMO Act, MCL §§ 500.3501 *et seq.*, but also the Social Welfare Act, MCL §§ 400.1 *et seq.* and state Medicaid rules, and federal law and regulation governing the activities of Medicaid managed care organizations, including the federal regulations at 42 CFR Part 438.

addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by [Medicaid Health Plans]." Medicaid Provider Manual, General Information for Providers, Section 12, p. 24 (available at http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html). See also, State of Michigan Qualified Health Plan Contract, Section II-M6(f) attached as Exhibit B (Requiring that the Medicaid HMO's provider contracts "prohibit the provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the Contract and requir[ing] the provider to look solely to the [Medicaid HMO] for compensation for services rendered.).

Instead, the HMO provider submits claims for covered health care services directly to the HMO, and the HMO processes the claim and is responsible for making payment directly to the provider. See MCL § 500.2006(7)-(14) and 400.111i;[7] See also 42 CFR § 438.106 (Medicaid HMO is responsible for ensuring enrollee is not liable for covered services), and State of Michigan Qualified Health Plan Contract, Section II-N attached as Exhibit C (Requiring the Medicaid HMO to "make timely payments to all providers for Covered Services rendered to Enrollees."). In fact, except in very limited circumstances, an HMO is prohibited from making any payment to an enrollee and, therefore, must pay the provider directly for covered health services. See MCL § 500.3517(1).[8]

[7] The cited statutory provisions are known as "prompt pay" statutes, and evidence the legislature's intent that health care providers receive timely payment in recognition of the fact that the HMO receives payment in advance, on behalf of its enrollees, for health care services the enrollees receive. To ensure prompt payment, these statutory provisions require the HMO to pay penalty interest, at the rate of 12% per year, on claims that are not timely paid. In this case, MHOP Providers were not paid timely and, in fact, payment is nearly two years overdue, entitling MHOP Providers to interest on their claims at the rate of 12% per year.

[8] The only exception that permits payment to be made to the enrollee involves situations where the enrollee receives emergency care, or other care specifically authorized by the HMO, from a provider not affiliated with the HMO where payment is not otherwise made directly to the service provider. MCL § 500.3517(2).

Thus, in the ordinary course of the operation of an HMO such as MHOP, claims for medical expenses associated with covered health care services for which the HMO is responsible are submitted by providers directly to the HMO, and not to enrollees. Those claims are received and processed by the HMO, and payment is made directly to the providers by the HMO.

This regulatory and operational framework, pursuant to which providers and HMOs deal directly with one another with regard to payment issues, and providers are prohibited from billing the member, is distinct from the regulatory and operational framework for traditional indemnity insurers. Under traditional indemnity insurance coverage, the insurance policy obligates the insurer to make a payment directly to the insured, or to a permitted assignee of the insured, for costs associated with health care received. The regulatory scheme does not require the insurer to make payments directly to providers, nor does it require providers to bill the insurer directly or prohibit the provider from billing the insured.

In the context of Section 8142, there is no dispute that claims for medical expenses submitted by the insured to a traditional indemnity insurer would be designated as Class 2 claims. These insured claims would be seeking reimbursement for medical expenses paid by the insured to the health care provider based on the bills sent by the provider to the insured. As explained above, in the HMO context, providers do not submit bills to the enrollees, and, indeed, are prohibited from doing so. Instead, the provider submits claims directly to the HMO, and deals directly with the HMO with respect to claims payment issues as a result of the regulatory framework governing HMO operations. The fact that the regulatory scheme requires providers to bill the HMO

directly, and the HMO to pay the provider directly, does not change the fundamental character of the claim, which is a claim for medical expenses covered under the health maintenance contract issued by the HMO.

Accordingly, for purposes of Section 8142, there is no meaningful distinction between a claim for health care benefits covered under an insurance policy and submitted by an insured to a traditional indemnity health insurer (which no one disputes are Class 2 claims) and a claim for health care benefits covered under a health maintenance contract and submitted by a health care provider to an HMO which should be treated, consistent with the claims of traditional indemnity insureds, as Class 2 claims for purposes of Section 8142.

3. Designating Provider Claims as Class 2 Claims Is Consistent With the Accounting Treatment Of Such Claims Mandated by OFIS

For accounting purposes, and as required by the Office of Financial and Insurance Services ("OFIS"), health care provider claims are treated as claims for losses incurred submitted under health maintenance contracts. OFIS requires HMOs, like MHOP, to report financial information in accordance with prescribed statutory accounting rules. See Order No. 04-073-M of OFIS Commissioner regarding Financial Statements and Accounting Practices and Procedures, available at www.michigan.gov/documents/cis_ofis_hmo_book_2003_80217_7.pdf. Under these statutory accounting rules, provider claims are reported as losses incurred and payments to providers are reported as benefit payments made under the HMOs health maintenance contracts. See Id., OFIS Form FIS-O320, which requires the reporting of hospital

services as "payouts" of HMO benefits, and OFIS Form FIS-0322 requiring the reporting of health care provider claims paid as "direct losses paid."[9]

Consistent with the reporting obligations specified by OFIS, MHOP reports health care provider claims as "losses incurred." See Annual Statement for MHOP for the Year Ending December 31, 2003, Part 2C, attached hereto as Exhibit D. Since the Rehabilitator treats HMO payments for health care provider claims as losses incurred for accounting purposes under the Insurance Code, and, as a result, this is how HMOs such as MHOP report provider claims, provider claims similarly should be treated as "losses incurred" for purposes of Section 8142 of that same Insurance Code.

B. Affording Provider Creditor Claims Class 2 Treatment Is Fair and Equitable

Health care providers, such as the Hospital Providers, have shouldered the vast majority of the burden associated with the rehabilitation of MHOP. Those providers were forced to write off tens of millions of dollars in pre-rehabilitation claims for services rendered to MHOP members. More than 41% of the amount "paid" by MHOP for pre-rehabilitation claims took the form of surplus notes. Those surplus notes will never be paid. As a result, in total, health care providers received $.29 for each dollar of pre-rehabilitation debt owed by MHOP. No other category of creditor was forced to write off debt of a magnitude anywhere near the tens of millions of dollars health care providers were forced to write off.

At the same time as they were forced to write off massive amounts of MHOP debt, health care providers were required to continue to do business with MHOP, so that MHOP could remain in business and maintain a provider network available to its

[9] FIS-0320 and FIS-0322 are attached to OFIS Commissioner Order No. 04-073-M

members. Accordingly, health care providers dutifully and diligently continued to treat and provide quality health care services to MHOP members, despite the fact MHOP remained insolvent and health care providers were at risk for a second write-off. No other creditors were similarly forced to continue doing business with MHOP for the good of MHOP members, the public and creditors, or otherwise. Yet, it is precisely because health care providers continued to do business with MHOP, and their arrangements with MHOP could be assigned to Coventry Health of Michigan, that the Rehabilitator was able to sell MHOP's membership to Coventry Health of Michigan, realizing approximately $10 million for MHOP. Indeed, this $10 million represents nearly 2/3 of the assets currently available to pay MHOP creditor claims.

As noted above, throughout the rehabilitation proceedings, health care providers were repeatedly assured that they would receive payment in full for all claims for services rendered to MHOP members following the initiation of rehabilitation proceedings. As we now know, this is not the case and health care providers, who already have written off $34.2 million in pre-rehabilitation claims and who will be forced to write off another $14 million in rehabilitation plan surplus notes, now face yet another write off.

As was the case with the rehabilitation plan write-offs, the vast majority of remaining creditor claims (83%) consist of health care provider claims and, therefore, regardless of where their claims are classified, health care providers again will incur the vast majority of the write-offs. Under such circumstances, given health care providers' previous write-offs, cooperation in the rehabilitation proceedings, and unfulfilled promises of payment with respect to post-rehabilitation claims, it is more than fair and

equitable to give health care provider claims the highest priority classification to which they are entitled, Class 2 treatment.

IV. Conclusion

Consistent with the treatment of claims for health care expenses submitted to traditional indemnity health insurers and the treatment of provider claims under OFIS' prescribed statutory accounting principles for HMOs, and in light of the fact that health care providers must bill the HMO directly, and the HMO pays the provider directly, and given that it is more than fair and equitable, health care provider claims should be treated as Class 2 claims for purposes of Section 500.8142. Accordingly, MHOP Providers respectfully request that this Court issue an order designating MHOP Provider's unpaid claims as Class 2 claims for purposes of the distribution of assets from MHOP's liquidation estate.

Respectfully submitted,

NUYEN, TOMTISHEN AND AOUN, P.C

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June 16, 2005

September 6, 2001

Dear OmniCare Customers:

This past April, OmniCare Health Plan of Michigan announced the steps that were being taken to enhance the financial future of its health plan and its ability to continue to serve the needs of its members. At that time, OmniCare Health Plan of Michigan had signed a letter of intent to consolidate its operations with The Detroit Medical Center (DMC). However, after extensive negotiations, DMC and OmniCare could not come to an agreement on the financial terms. Subsequent to these discussions, the State of Michigan's Office of Financial and Insurance Services (OFIS) petitioned the courts to place OmniCare of Michigan into rehabilitation.

The rehabilitation status places the Commissioner of Financial and Insurance Services, Frank M. Fitzgerald, in charge to ensure the continuation of services. The rehabilitation process allows the OFIS to make arrangements to preserve OmniCare's providers, minimize any disruption of services to members and to work towards preserving OmniCare Health Plan as a health care resource.

One of the first steps that have been taken as part of the rehabilitation process is the appointment of two Deputy Rehabilitators who will assist the OFIS Commissioner in stabilizing and initiating a corrective action plan. These appointees are Mr. Bobby L. Jones and Ms. Beverly Allen. Mr. Jones and Ms. Allen's' extensive financial and managed care backgrounds as well as their familiarity with OmniCare Health Plan makes for a promising future for the health plan.

OmniCare is a health plan that has been in existence for almost 30 years. It has an extensive history in Michigan and serves over 100,000 covered lives. Every effort will be made to ensure its continuation.

We realize that as a dedicated OmniCare customer you have many questions that you are concerned with during this period of rehabilitation. Therefore we have developed the following "Fact Sheet" that will address many of your concerns.

Thank you for your continued support.

Sincerely,

OmniCare Health Plan

OmniCare Rehabilitation Fact Sheet

Members

Billing:

As a member of OmniCare you will continue to receive covered services, and that care will be paid by OmniCare. Since contracted OmniCare Providers, formerly or current, entered into an agreement with OmniCare they have a "hold harmless" clause in their contract, which indicates that they cannot bill or balance bill the member for services rendered, with the exception of applicable co-payments. Therefore, if a bill collection agency attempts to collect from you, please refer them to OmniCare's Customer Care Department 1-800-477-6664 or they may go to www.ochp.com to review the hold harmless clause for HMOs.

Obtaining Care:

As a member of OmniCare you are entitled to receive uninterrupted care. Please do not hesitate in contacting the Customer Care department should you have problems with a provider who indicates that he or she no longer accepts OmniCare. If they were a contracted provider on July 31, 2001 they are mandated by the courts to continue to provide care for OmniCare members.

Plan Services:

OmniCare's Customer Care Department is still available to you should you have any questions and or concerns regarding the Plan, how to enroll and benefit services. Please visit our new updated website at www.ochp.com.

Providers

Billing:

As a former, current, or a non-contracted provider of OmniCare, Section 500.3529 and the rehabilitation court order prohibits the balance billing and obtaining judgements against OmniCare subscribers. All referrals to collection agencies are to cease in compliance with Michigan law and the order of the court.

Reimbursement:

As part of the rehabilitation court, OmniCare, under the direction of the OFIS will provide payment on a going forward basis effective 7/31/01. That means that if you submit a claim for the date of service of 7/31/01 and thereafter, you will be paid. Reimbursement for billing prior to 7/31/01 is yet to be determined by the OFIS. Providers will be promptly advised upon final determination.

Collection Agencies

If you are a collection agency that has been retained by a former, current or non-contracted provider, you are attempting to collect a debt that an OmniCare subscriber is not legally obligated to pay under the Michigan law and the rehabilitation court order. Please cease all collection activities. If you have made a negative notation on a subscriber's credit report, please make arrangements to immediately have the negative notations removed!

Employers

Billing:

Your employees will continue to receive care, and that care will be paid for. Since contracted OmniCare Providers, formerly or current, entered into an agreement with OmniCare they have a "hold harmless" clause in their contract, which indicates that they cannot bill or balance bill the member for services rendered, with the exception of applicable co-payments. Therefore, if a bill collection agency attempts to collect from you, please refer them to OmniCare's Customer Care Department 1-800-477-6664 or they may go to www.ochp.com to review the hold harmless clause for HMOs.

Obtaining Care:
Your employees are entitled to receive uninterrupted care. Please do not hesitate to have your employees contact Customer Care if they are having problems with a provider who indicates that he or she no longer accepts OmniCare. If they were a contracted provider on July 31, 2001 they are mandated by the courts to continue to provide care for OmniCare members.

Plan Services:
If your employees have any questions or concerns regarding the Plan, enrollment or benefit services please have them contact OmniCare's Customer Care Department at 1-800-477-6664, or visit our new updated website at www.ochp.com.

Terminations:
All employer groups currently contracted with OmniCare Health Plan for health care services are restricted by court order from terminating such relationship prior to the expiration date of the existing contract. Please refer to the Ingham County Court Order on the OmniCare web site.

Enrollment:
OmniCare Health Plan will continue to accept new members during open enrollment periods. Representatives of OmniCare will continue to attend enrollments, health fairs and other events sponsored by our employer groups.

Contact Us:
Please do not hesitate to contact your Group Services Representative at 1-800-925-4550 if you have any further questions or concerns.

Agents

Reimbursement:
As licensed agents of OmniCare Health Plan, you will still receive your scheduled commission payments. Please keep in mind that your groups are restricted by court order from terminating their relationship with OmniCare prior to the expiration date of the contract.

On behalf of the Office of Financial and Insurance Services we sincerely appreciate employer, union, and agent cooperation and continued support during this rehabilitation.

THIS NOTICE HAS BEEN REVIEWED BY THE STATE OF MICHIGAN ATTORNEY GENERAL'S OFFICE AND HAS BEEN APPROVED FOR BOTH FORM AND CONTENT.

PRINTER friendly

Contact: OFIS Commissioner's Office 517-335-3167 OFIS Toll Free 877-999-6442
Agency: Financial and Insurance Services

Rehabilitation Petitioned for OmniCare Health Plan

FOR IMMEDIATE RELEASE: **July 31, 2001**

(LANSING, MI) - "Late yesterday afternoon, I petitioned the Ingham County Circuit Court to place OmniCare Health Plan into a court-ordered rehabilitation pursuant to Michigan statute," said Michigan's Financial and Insurance Services Commissioner Frank M. Fitzgerald. "It is important for OmniCare members and providers to know that through this action OmniCare will continue to provide services and pay its bills."

This action comes after 3 years of supervision of OmniCare by the Office of Financial and Insurance Services (OFIS). OmniCare reported a negative net worth of over $8 million for the 2000 calendar year end. Its financial condition has continued to deteriorate through 2001.

In late March the Detroit Medical Center (DMC) announced its intention to purchase OmniCare. Extensive negotiations between the DMC and OmniCare ensued, but ended last week without an agreement to conclude the sale.

If the Ingham County Circuit Court grants the petition and orders rehabilitation, Fitzgerald said he will be able to preserve OmniCare's networks, pay providers, minimize any disruption of service, and work towards preserving OmniCare as a health care resource.

"As the major health care provider to OmniCare members," Fitzgerald continued, "the rehabilitation plan will include a new arrangement with the Detroit Medical Center under which the hospital system continues its services to OmniCare members. DMC is doing this as part of its commitment to patients and the community."

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"The Department of Community Health is working closely with providers to ensure that Medicaid beneficiaries continue to receive quality health care services," said Michigan Department of Community Health Director James K. Haveman, Jr. "Through the Commissioner's efforts, we have worked to ensure there is no interruption of services for Medicaid beneficiaries and that quality health care services will continue."

What rehabilitation means to OmniCare members: If you hold insurance through OmniCare, you will continue to receive care, and that care will be paid for: The rehabilitation will put the Commissioner, as court ordered rehabilitator, in charge of OmniCare, provide payment for your health care on a going forward basis, and restructure current debts. For questions about your coverage, call OmniCare's Customer Care Call Center toll free at (800) 477-6664. Consumers who receive Medicaid through OmniCare can also call (800) 642-3195

What rehabilitation means to OmniCare providers: OFIS is now able to provide for payment on a going forward basis. The rehabilitation proceedings will include a plan for the payment of past obligations to creditors on a fair basis in accordance with OmniCare's resources. Providers with questions or comments about the rehabilitation action can call the OmniCare Provider Inquiry Line toll free at (888) 640-9855.

Overall, financial conditions for Michigan HMOs are improving. Michigan has not taken any statutory financial action against an HMO since the late 1980s. "There are eighteen managed care plans successfully providing services to Michigan's Medicaid population," said Fitzgerald. "Factors other than OmniCare's Medicaid participation are causing me to act in this situation."

OmniCare began operation in 1975. It has approximately 66,000 Medicaid members, 27,500 commercial members, and 3,800 Point of Service members.

OmniCare rehabilitation documents:

- Verified Petition
- Preliminary Order of Rehabilitation and Injunctive Relief
- Order to Show Cause
- Link to the OmniCare website for additional information - http://www.ochp.com
- OmniCare Rehabilitation Team

Further updates will also be posted to this site.

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The Michigan Offices of Financial and Insurance Services (OFIS) is responsible for the regulation of Blue Cross Blue Shield, 29 HMOs; 146 banks, 175 domestic insurance companies, 291 credit unions, 1,300 foreign insurance companies, 1,583 investment advisers, 2,164 securities broker-dealers, 6,000 consumer finance lenders, 75,000 insurance agents, and 120,715 securities agents. OFIS is part of the Department of Consumer and Industry Services and is primarily fee-funded, requiring minimal public tax dollars for its regulatory and consumer assistance activities. OFIS has insurance, financial institutions and securities information available on the web at www.michigan.gov/ofis.

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Contact: OFIS Commissioner's Office 517-335-3167 OFIS Toll Free 877-999-6442
Agency: Financial and Insurance Services

OmniCare Rehabilitation Plan Filed With Court

FOR IMMEDIATE RELEASE: **March 14, 2002**

Approval by Court to be Determined This Spring

(LANSING, MI) - Michigan Office of Financial and Insurance Services (OFIS) Commissioner Frank M. Fitzgerald today filed the OmniCare Health Plan rehabilitation plan with the Ingham County Circuit Court. A hearing will be held in April to determine court approval of the plan.

"When OmniCare was placed into rehabilitation last July, I was charged with determining if this health plan could operate in a manner that is safe, sound, and entitled to public confidence," said Fitzgerald. "I am informing the court through this plan that rehabilitation - not liquidation - is the correct course of action for OmniCare Health Plan."

Highlights of the rehabilitation plan include investment in OmniCare's information technology systems and a marketing plan that identifies and pursues growth opportunities. The rehabilitation plan also includes ending the management agreement with United American Healthcare, restructuring of debts to providers related to the pre-rehabilitation period, a potential OmniCare conversion to for-profit status, continuing National Committee for Quality Assurance (NCQA) accreditation, and continuing quality improvements. OmniCare will likely remain in rehabilitation status after the hearing and has been granted an extension by OFIS for filing the 2001 annual financial statement.

The proposed plan of rehabilitation presents the Court with a schedule of payments for creditors owed money prior to the date of rehabilitation (July 31, 2001). Creditors of OmniCare will receive notice of this filing and have until April 11, 2002 to file objections to the proposed plan. The Court will hold a hearing

Wage & Hour Division

on the proposal on April 25, 2002. The Court then will decide whether to accept, reject, or modify the proposal.

"OmniCare has operated profitably since the first day of rehabilitation on August 1, 2001," said Fitzgerald. "Indeed, the plan projects a profit of over $4 million dollars during calendar year 2002. These profitable and efficient operations make it possible to propose rehabilitation, rather than liquidation, to the Court."

What rehabilitation means to OmniCare members: If you hold insurance through OmniCare, you will continue to receive care for covered services and your providers (doctors, hospitals, etc.) will be reimbursed. The rehabilitation continues to provide payment for your health care on a going forward basis and restructures debts to providers related to the pre-rehabilitation period. For questions about your coverage, call OmniCare's Customer Care Call Center toll free at (800) 477-6664. Consumers receiving Medicaid from OmniCare can also call (800) 642-3195.

What rehabilitation means to OmniCare providers and creditors: The rehabilitation plan continues to provide for payment for services on a going forward basis. The plan includes payment of past obligations to creditors on a fair basis in accordance with OmniCare's resources. Providers with questions about the rehabilitation action can call the OmniCare Provider Inquiry Line toll free at (888) 640-9855. Creditors can review their specific information via the CDs being mailed directly or on the OFIS web site.

The rehabilitation plan will be available in its entirety on the OFIS web site at www.michigan.gov/ofis - electronically linked below.

OFIS REHABILITATION PLAN FOR OMNICARE HEALTH PLAN:

Frequently Asked Questions
- Members
- Employers
- Providers

Plan as filed with the Ingham County Circuit Court on 3/12/02
- OmniCare Rehabilitation Plan
- Attachment A - Glossary
- Attachment B - OmniCare Board of Trustees and Sub-Committees
- Attachment C - Management Organization Chart (3.2 MB)

Attachment D - Management Team Bios
Attachment E - Information Systems Landscape - Current
Attachment F - Information Systems Landscape - Proposed
Attachment G - Liquidation Scenario
Attachment H - Provider Notice - Documents (1.1 MB)
Attachment I - Schedule of Medical Claims Liabilities
Attachment J - Debt Restructure Table
Attachment K - Provider Debt Reconsolidation
Attachment L - Schedule of Capitation Withholding Liabilities
Attachment M - December 31, 2000 Financials
Attachment N - July 31, 2001 Balance Sheet (Restated)
Attachment O - Financial Performance August 2001 through December 2001 (Restated)
Attachment P - 2002 Budget Projections
Attachment Q - 5 Year Financial Projections
Attachment R - Community Testimonies (2.5 MB)

Notices

Notice of Deadline
Publication of Notice
Notice of Filing of the Proposed Rehabilitation Plan (8.7 MB - Very large file. May be slow to download)

Petitions

Notice of Hearing and Procedures for the Approval of the Rehabilitation Plan
Petition of Approval for the Proposed Rehabilitation Plan

Orders

Preliminary Order - July 31, 2001 (524 KB)
Order of Rehabilitation and Injunctive Relief - September 11, 2001 (6.0 MB - Very large file. May be slow to download)

Information for Creditors

Instructions for locating unpaid liabilities

Additional OmniCare Information

- OmniCare rehabilitation announcement 7/31/01 - www.michigan.gov/cis/1,1607,7-154-10555_13222_13250-39458--M_2001_7,00.html
- OFIS Press Release "OmniCare Turns A Profit" 10/19/01 - www.michigan.gov/cis/1,1607,7-154-10555_13222_13250-39465--M_2001_10,00.html
- OmniCare web site - www.ochp.com

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must collect service-specific procedures and diagnosis data, to price specific procedures or encounters (depending on the agreement between the provider and the Contractor), and maintain detailed records of remittances to providers. The Contractor is responsible for annual IRS form 1099 reporting of provider earnings.

Management information systems capabilities are necessary for at least the following areas:

- Member enrollment
- Provider enrollment
- Third party liability activity
- Claims payment
- Grievance and complaint tracking
- Tracking and recall for immunizations, well-child visits/EPSDT, and other services as required by DCH
- Encounter reporting
- Quality reporting
- Member access and satisfaction

5. Governing Body

Each Contractor will have a governing body that has a minimum of 1/3 of its membership consisting of adult Enrollees who are not compensated officers, employees, stockholders who own more than 5% of the shares of the Contractor's plan, or other individuals responsible for the conduct of, or financially interested in, the Contractor's affairs. The Contractor must have written policies and procedures detailing how Enrollee board members will be elected, the length of the term, filling of vacancies, notice to Enrollees and subscribers, etc. The governing body will ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The Enrollee board members must have the same responsibilities as other board members in the development of policies governing the operation of the Contractor's plan. The administrator or executive officer that oversees the day-to-day conduct and operations of the Contractor will be responsible to the governing body. The governing body must meet at least quarterly, and must keep a permanent record of all proceedings that is available to DCH and/or HCFA on request.

6. Provider Network in the CHCP

(a) General

The Contractor is solely responsible for arranging and administering Covered Services to Enrollees. Covered Services shall be medically necessary and administered, or arranged for, by a designated PCP. Enrollees shall be provided with an opportunity to select their PCP. If the Enrollee does not choose a PCP at the time of enrollment, it is the Contractor's responsibility to assign a PCP within one month of the effective date of enrollment. If the Contractor cannot honor the Enrollee's choice of the PCP, the Contractor must contact the Enrollee to allow the Enrollee to either make a choice of an alternative PCP or to disenroll. The Contractor must notify all Enrollees assigned to a PCP whose provider contract will be terminated and assist them in choosing a new PCP prior to the termination of the provider contract.

The Contractor must ensure that the provider network:

- provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of Covered Services.
- guarantees that emergency services are available seven days a week, 24-hours per day.
- demonstrates that it can maintain a delivery system of sufficient size and resources to offer quality care that accommodates the needs of the enrolled Beneficiaries within each enrollment area.
- assures that contracted PCPs provide or arrange for coverage of services 24 hours a day, 7 days a week and PCPs must be available to see patients a minimum of 20 hours per practice location per week.
- responds to the cultural, racial and linguistic needs (including interpretive services as necessary) of the Medicaid population.
- is described in the provider files for PCPs and other providers that are submitted to the Department's Enrollment Services Contractor.
- will have sufficient capacity to handle the maximum number of Enrollees specified under this Contract.

Provider files will be used to give Beneficiaries information on available Contractors and to ensure that the provider networks identified for Contractors are adequate in terms of number, location, and hours of operation. The Contractor will ensure:

- that it will provide to DCH's Enrollment Services contractor provider files which contain a complete description of the provider network available to Enrollees;
- that provider files will be submitted in the format specified by DCH;
- that provider files will be updated as necessary to reflect the existing provider network;
- that provider files will be submitted to DCH's Enrollment Services contractor in a timely manner;
- that it will provide to DCH's Enrollment Services contractor a description of the Contractor's service network, including but not limited to: the specialty and hospital network available, arrangements for provision of medically necessary non-contracted specialty care; any family planning services network available, any affiliations with Federally Qualified Health Centers, Rural Health Clinics, and Adolescent Health Centers; arrangements for access to obstetrical and gynecological services; availability of case management or care coordination services; and arrangements for provision of ancillary services. The description will be updated as necessary;
- that the services network will be submitted to DCH's Enrollment Services contractor in a timely manner in the format requested

The Contractor will ensure:

- that selected PCPs are accessible taking into account travel time, availability of public transportation and other factors that may determine accessibility;
- that primary care and hospital services will be available to Enrollees within 30 minutes or 30 miles travel. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minutes or 30 miles travel time. For pharmacy services, the State's expectations are that the Contractor will ensure access within 30 minutes travel time and that services will be available during evenings and on weekends;
- that reasonable access to specialists will be based on the availability and distribution of such specialists;

- that adequate access exists for ancillary services such as pharmacy services, durable medical equipment services, home health services, and Maternal and Infant Support Services;
- that arrangements for laboratory services will be through only those laboratories with CLIA certificates;
- that all ancillary providers and facilities must be appropriately licensed or certified if required under 1978 PA 368, as amended.

(b) Mainstreaming

DCH considers mainstreaming of Enrollees into the broader health delivery system to be important. The Contractor must have guidelines and a process in place to ensure that Enrollees are provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap. In addition, the Contractor must ensure that:

- Enrollees will not be denied a Covered Service or availability of a facility or provider identified in this Contract.
- Network providers will not intentionally segregate Enrollees in any way from other persons receiving health care services.

(c) Public and Community Providers and Organizations

Contractors must work closely with local public and private community-based organizations and providers to address prevalent health care conditions and issues. Such agencies and organizations include local health departments, local FIA offices, family planning agencies, Substance Abuse Coordinating Agencies, community and migrant health centers, school based and adolescent health centers, and local or regional consortiums centered around various health conditions. Local coordination and collaboration with these entities will make a wider range of essential health care and support services available to the Contractor's Enrollees. Each county has a different array of these providers, and agencies or organizations. Contractors are encouraged to coordinate with these entities through participation of their provider networks in Michigan's county-based community health assessment and improvement process and multipurpose human services collaborative bodies.

A local coordination matrix is provided in the Appendix of this Contract. The Contractor is encouraged to use this document as a guide for establishing coordination and collaboration practices and protocols with local public health agencies. To ensure that the services provided by these agencies are available to all Contractors, an individual Contractor shall not require an exclusive contract as a condition of participation with the Contractor.

It is also beneficial for Contractors to collaborate with non-profit organizations that have maintained a historical base in the community. These entities are seen by many Enrollees as "safe harbors" due to their familiarity with the cultural standards and practices within the community. For example, adolescent health centers are specifically designed to be accessible and acceptable, and are viewed as a "safe harbor" where adolescents will seek rather than avoid or delay needed services.

(d) Local Behavioral Health and Developmental Disability Provider Agreements

Some Enrollees in each Contractor's plan may also be eligible for services provided by Behavioral Health Services and Services for Persons with Developmental Disabilities managed care programs. Contractors are not responsible for the direct delivery of specified behavioral health and developmental disability services. The Contractor will establish and maintain local agreements with behavioral health and developmental disability agencies or organizations contracting with the State.

Contractors must ensure that local agreements address the following issues:

- Emergency services
- Pharmacy and laboratory service coordination
- Medical coordination
- Data and reporting requirements
- Quality assurance coordination
- Grievance and complaint resolution
- Dispute resolution

Examples of local agreements are included in the Appendix of this Contract.

(e) Network Changes

Contractors will notify DCH within seven (7) days of any changes to the composition of the provider network that affects the Contractor's ability to make available all Covered Services in a timely manner. Contractors will have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that DCH determines to negatively affect Enrollees' access to Covered Services may be grounds for sanctions or Contract termination.

If the Contractor expands the PCP network within a county and can serve more Enrollees the Contractor may submit a request to DCH to increase capacity. The request must include details of the changes that would support the increased capacity. Contractor must use the format specified by DCH to describe network capacity.

(f) Provider Contracts

In addition to HMO licensure requirements, Contractor provider contracts will meet the following criteria:

- Prohibit the provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the Contract and require the provider to look solely to the Contractor for compensation for services rendered. No cost-sharing or deductibles can be collected from Enrollees. Co-payments are only permitted with DCH approval.
- Require the provider to cooperate with the Contractor's quality improvement and utilization review activities.
- Include provisions for the immediate transfer of Enrollees to another Contractor PCP if their health or safety is in jeopardy.
- Cannot prohibit a provider from discussing treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor.

- Cannot prohibit a provider from advocating on behalf of the Enrollee in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.
- Require providers to meet Medicaid accessibility standards as established in Medicaid policy.

In accordance with Section 1932 (b)(7) of the Social Security Act as implemented by Section 4704(a) of the Balanced Budget Act, Contractors may not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision should not be construed as an "any willing provider" law, as it does not prohibit Contractors from limiting provider participation to the extent necessary to meet the needs of the Enrollees. This provision also does not interfere with measures established by Contractors that are designed to maintain quality and control costs consistent with the responsibility of the organization.

(g) Disclosure of Physician Incentive Plan

Contractors will annually disclose to DCH the information on their provider incentive plans listed in 42 CFR 417.479(h)(1) and 417.479(i), as required in 42 CFR 434.70(a)(3), in order to determine whether the incentive plans meet the requirements of 42 CFR 417.479 (d) — (g) when there exists compensation arrangements under the Contract where payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under Section 1903 (s) of the Social Security Act. The Contractor will provide the information on its physician incentive plans listed in 42 CFR 417.479(h)(3) to any Enrollee.

(h) Provider Credentialling

The Contractor will have written credentialling and re-credentialling (at least every two years) policies and procedures for ensuring quality of care and ensuring that all providers rendering services to their Enrollees are licensed by the State and are qualified to perform their services throughout the life of the Contract. The Contractor must ensure that network providers residing and providing services in bordering states meet all applicable licensure and certification requirements within their state. The Contractor also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the Contractor's medical management standards.

(i) PCP Standards

The Contractor must offer its Enrollees freedom of choice in selecting a PCP. The Contractor will have written policies and procedures describing how Enrollees choose and are assigned to a PCP, and how they may change their PCP. The PCP is responsible for supervising, coordinating and providing all primary care to each assigned Enrollee. In addition, the PCP is responsible for initiating referrals for specialty care, maintaining continuity of each Enrollee's health care, and maintaining the Enrollee's medical record which includes documentation of all services provided by the PCP as well as any specialty or referral services.

The Contractor will allow a specialist to perform as a PCP when the Enrollee's medical condition warrants management by a physician specialist. This may be necessary for those Enrollees with conditions such as diabetes, end-stage

renal disease or other chronic disease or disability. The need for management by a physician specialist should be determined on a case-by-case basis in consultation with the Enrollee. If the Enrollee disagrees with the Contractor's decision, the Enrollee should be informed of his or her right to file a grievance with the Contractor and/or to file an appeal with DCH.

The Contractor will ensure that there is a reliable method and system for providing 24 hour access to urgent care and emergency services 7 days a week. All PCPs within the network must have information on the system and must reinforce with their Enrollees the appropriate use of health care services. Routine physician and office visits must be available during regular and scheduled office hours. Provisions must be available for obtaining urgent care 24 hours a day. Urgent care may be provided directly by the PCP or directed by the Contractor through other arrangements. Emergency Services must always be available.

Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.

At a minimum, the Contractor shall have or provide one full-time PCP per 2,000 members. This ratio shall be used to determine maximum Enrollment Capacity for the Contractor in an approved service area.

The Contractor will assign a PCP who is within 30 minutes or 30 miles travel time to the Enrollee's home, unless the Enrollee chooses otherwise. Exceptions to this standard may be granted if the Contractor documents that no other network or non-network provider is accessible within the 30 minute or 30 mile travel time. The Contractor will take the availability of handicap accessible public transportation into consideration when making PCP assignments.

PCPs must be available to see Enrollees a minimum of 20 hours per practice location per week. This provision may be waived by DCH in response to a request supported by appropriate documentation. Specialists are not required to meet this standard for minimum hours per practice location per week. In the event that a specialist is assigned to act as a PCP, the Enrollee must be informed of the specialist's business hours. In circumstances where teaching hospitals use residents as providers in a clinic and a supervising physician is designated as the PCP by the Contractor, the supervising physician must be available at least 20 hours per practice location per week.

The Contractor will ensure that some providers offer evening and weekend hours of operation in addition to scheduled daytime hours. The Contractor will provide notice to Enrollees of the hours and locations of service for their assigned PCP.

The Contractor will monitor waiting times to get appointments with providers, as well as the length of time actually spent waiting to see the provider. This data must be reported to DCH upon request. The Contractor will have established criteria for monitoring appointment scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to DCH upon request.

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The Contractor will ensure that a maternity care provider is designated for an enrolled pregnant woman for the duration of her pregnancy and postpartum care. A maternity care provider is a provider meeting the Contractor's credentialling requirements and whose scope of practice includes maternity care. An individual provider must be named as the maternity care provider to assure continuity of care. An OB/GYN clinic or practice cannot be designated as a PCP or maternity care provider. Designation of individual providers within a clinic or practice is appropriate as long as that individual, within the clinic or practice, agrees to accept responsibility for the Enrollees care for the duration of the pregnancy and post-partum care.

For maternity care, the Contractor will be able to provide initial prenatal care appointments for enrolled pregnant women according to standards developed by the CAC and the QIC.

II-N PAYMENT TO PROVIDERS

The Contractor will make timely payments to all providers for Covered Services rendered to Enrollees. With the exception of newborns, the Contractor will not be responsible for any payments owed to providers for services rendered prior to a Beneficiary's enrollment with the Contractor's plan. Except for newborns, payment for services provided during a period of retroactive eligibility will be the responsibility of DCH.

1. Electronic Billing Capacity

   The Contractor must meet the following timeframes for electronic billing capacity and may require its providers to meet the same standard as a condition for payment:

   (a) Be capable of accepting electronic billing for HCFA 1500 and UB 92 no later than May 31, 2000;
   (b) Be capable of accepting electronic billing for UB 92 (Inpatient and Outpatient Claims) with Medicare format standards no later than September 30, 2000;
   (c) Be capable of accepting electronic billing for HCFA 1500 claims with Medicare format standards no later than December 31, 2000.

2. Prompt Payment

   Contractors must meet the prompt payment requirements as stated in 2000 PA 187.

3. Payment Resolution Process

   The Contractor will have an effective provider appeal process to promptly resolve provider billing disputes. The Contractor will cooperate with providers who have exhausted the Contractor's appeal process by entering into arbitration or other alternative dispute resolution process.

4. Arbitration

9558220032010010 2003 Document Code: 201

ANNUAL STATEMENT

For the Year Ending December 31, 2003

OF THE CONDITION AND AFFAIRS OF THE

OmniCare Health Plan

NAIC Group Code 0000 (Current Period), 0000 (Prior Period) NAIC Company Code 95582 Employer's ID Number 38-2031377

Organized under the Laws of Michigan, State of Domicile or Port of Entry Michigan

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health[ ] Property/Casualty[ ] Hospital, Medical & Dental Service or Indemnity[ ]
Dental Service Corporation[ ] Vision Service Corporation[ ] Health Maintenance Organization[X]
Other[ ] Is HMO Federally Qualified? Yes[X] No[ ]

Date Incorporated or Organized 09/23/1972 Date Commenced Business 12/23/1973

Statutory Home Office 1155 Brewery Park, Suite 250 (Street and Number), Detroit, MI 48207 (City, or Town, State and Zip Code)

Main Administrative Office 1155 Brewery Park, Suite 250 (Street and Number)
Detroit, MI 48207 (City or Town, State and Zip Code) (313)393-2379 (Area Code) (Telephone Number)

Mail Address 1155 Brewery Park, Suite 250 (Street and Number or P.O. Box), Detroit, MI 48207 (City, or Town, State and Zip Code)

Primary Location of Books and Records 1155 Brewery Park, Suite 250 (Street and Number)
Detroit, MI 48207 (City, or Town, State and Zip Code) (313)393-2379 (Area Code) (Telephone Number)

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Krogers@ochp.com (E-Mail Address) (313)393-4743 (Fax Number)

Policyowner Relations Contact (Street and Number)
(City, or Town, State and Zip Code) (Area Code) (Telephone Number) (Extension)

OFFICERS

Deputy Rehabilitator Bobby L. Jones
Deputy Rehabilitator Beverly Allen

VICE PRESIDENTS

DIRECTORS OR TRUSTEES

Herman B. Gray M.D.
Tej Mattoo M.D.
George Shade M.D.

State of Michigan
County of Wayne ss

The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively.

(Signature)	(Signature)	(Signature)
Bobby Jones	Beverly Allen	
(Printed Name)	(Printed Name)	(Printed Name)
Deputy Rehabilitator	Deputy Rehabilitator	Treasurer

a. Is this an original filing? Yes[X] No[ ]
b. If no, 1. State the amendment number
2. Date filed
3. Number of pages attached

Subscribed and sworn to before me this
____ day of ____, 2004

(Notary Public Signature)

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS (000 Omitted)

Grand Total

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	109,650	39,851	2,928
5. 2002	XXX	XXX	XXX	136,670	17,338
6. 2003	XXX	XXX	XXX	XXX	132,606

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	189,951	154,682	155,057
5. 2002	XXX	XXX	XXX	155,938	154,635
6. 2003	XXX	XXX	XXX	XXX	150,958

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. Prior to 1999	XXX			XXX		XXX				XXX
2. 1999										
3. 2000										
4. 2001	192,770	152,430	1,565	1.027	153,995	79.885	2,626		156,621	81.248
5. 2002	172,815	154,007	1,062	0.690	155,069	89.731	628	4	155,701	90.097
6. 2003	172,579	132,606	1,200	0.905	133,806	77.533	18,352	161	152,319	88.260
7. TOTAL (Lines 1 through 6)	XXX	439,043	3,827	XXX	442,870	XXX	21,606	165	464,641	XXX
8. TOTAL (Lines 2 through 6)	538,164	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

12 Total

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS (000 Omitted)

Hospital and Medical

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	28,974	8,892	1,028
5. 2002	XXX	XXX	XXX	21,634	4,803
6. 2003	XXX	XXX	XXX	XXX	16,490

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	52,786	39,386	39,682
5. 2002	XXX	XXX	XXX	26,584	26,610
6. 2003	XXX	XXX	XXX	XXX	21,386

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. Prior to 1999	XXX			XXX		XXX				XXX
2. 1999										
3. 2000										
4. 2001	44,298	38,894	271	0.697	39,165	88.413	788		39,953	90.191
5. 2002	33,559	26,437	204	0.772	26,641	79.386	173	2	26,816	79.907
6. 2003	27,696	16,490	146	0.885	16,636	60.066	4,896	27	21,559	77.842
7. TOTAL (Lines 1 through 6)	XXX	81,821	621	XXX	82,442	XXX	5,857	29	88,328	XXX
8. TOTAL (Lines 2 through 6)	105,553	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Medicare Supplement .... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Medicare Supplement ... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Medicare Supplement ... NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Dental Only..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Dental Only..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Dental Only..... NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Vision Only..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Vision Only..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Vision Only..... NONE

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS (000 Omitted)

Federal Employees Health Benefits Plan Premiums

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	2,484	1,219	23
5. 2002	XXX	XXX	XXX	5,772	738
6. 2003	XXX	XXX	XXX	XXX	5,957

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	8,354	4,050	3,886
5. 2002	XXX	XXX	XXX	6,596	6,515
6. 2003	XXX	XXX	XXX	XXX	6,723

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. Prior to 1999	XXX			XXX		XXX				XXX
2. 1999										
3. 2000										
4. 2001	6,104	3,727	60	1.610	3,787	62.041	158		3,945	64.630
5. 2002	7,382	6,509	39	0.599	6,548	88.702	5		6,553	88.770
6. 2003	7,240	5,957	59	0.990	6,016	83.094	766	9	6,791	93.798
7. TOTAL (Lines 1 through 6)	XXX	16,193	158	XXX	16,351	XXX	929	9	17,289	XXX
8. TOTAL (Lines 2 through 6)	20,726	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS (000 Omitted)

Title XVIII - Medicare

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999	NONE				
3. 2000					
4. 2001		XX			
5. 2002		XX	XXX		
6. 2003	XXX	XXX	XXX	XXX	

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999	NONE				
3. 2000					
4. 2001		XX			
5. 2002		XX	XXX		
6. 2003	XXX	XXX	XXX	XXX	

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. Prior to 1999	XXX			XXX		XXX				XXX
2. 1999										
3. 2000										
4. 2001					NONE					
5. 2002										
6. 2003										
7. TOTAL (Lines 1 through 6)	XXX			XXX		XXX				XXX
8. TOTAL (Lines 2 through 6)		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS (000 Omitted)

Title XIX - Medicaid

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	78,192	29,740	1,877
5. 2002	XXX	XXX	XXX	109,264	11,797
6. 2003	XXX	XXX	XXX	XXX	110,159

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability and Reserve Outstanding at End of Year				
	1 1999	2 2000	3 2001	4 2002	5 2003
1. Prior					
2. 1999					
3. 2000	XXX				
4. 2001	XXX	XXX	128,811	111,246	111,489
5. 2002	XXX	XXX	XXX	122,758	121,510
6. 2003	XXX	XXX	XXX	XXX	122,849

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. Prior to 1999	XXX			XXX		XXX				XXX
2. 1999										
3. 2000										
4. 2001	142,368	109,809	1,234	1.124	111,043	77.997	1,680		112,723	79.177
5. 2002	131,874	121,061	819	0.677	121,880	92.422	450	2	122,332	92.764
6. 2003	137,643	110,159	995	0.903	111,154	80.755	12,690	125	123,969	90.066
7. TOTAL (Lines 1 through 6)	XXX	341,029	3,048	XXX	344,077	XXX	14,820	127	359,024	XXX
8. TOTAL (Lines 2 through 6)	411,885	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX